FOSTER CARE CONTINGENCY FUND CLAIM FORM

FOSTER PARENTS' or CHILD PLACING AGENCY'S INFORMATION (CPA) ____ / _____ / _____
TODAY'S DATE

LOCALITY NAME WHO HAS CUSTODY OF CHILD(REN) INVOLVED: _____

_____ Duns Number/FIN: _____ - _____
Child Placing Agency Name (if applicable)

FOSTER PARENT (S) INFORMATION

_____ Social Security Number: _____ - _____ - _____
First Name Last Name

_____ Social Security Number: _____ - _____ - _____
First Name Last Name

_____ Home Phone (____) _____ - _____
Street Address City State Zip code Work Phone (____) _____ - _____

List the name of Foster Child (ren) involved

1. _____ Date Foster Parent(s)/CPA Discovered Damages __ / __ / ____
First Name Last Name Age Did Foster Parent(s)/CPA file insurance Claim? ☐ Yes ☐ No
2. _____ If so, what was the amount of the deductible? _____
First Name Last Name Age
*Complete another claim form if more then two foster children are involved.

AGENCY INFORMATION

Agency Worker Information

_____ Phone Number: _____ - _____ - _____
First Name Last Name

_____
Street Address City/County State Zip code

Date Worker Received Initial Report of Damage(s) _____ / _____ / _____
Date Worker Observed Damage(s) _____ / _____ / _____

Describe How and What was Damaged:

_____

_____

_____

Total Amount Requested **$**

Summary of Social Worker's Discussion with Child/Foster Parent:

_____

_____

_____

Precautionary Measures to Prevent Recurrence:

_____

_____

_____

(1) Foster Parent Signature _____ Date ____ / ____ / _____

(2) Foster Parent Signature _____ Date ____ / ____ / _____

Worker's Signature _____ Date ____ / ____ / _____

Director's (or) Designee's Signature _____ Date ____ / ____ / _____

*** ALL INFORMATION ON THE FORM MUST BE COMPLETED IN ORDER TO PROCESS CLAIM REQUEST***

Submit Form to:
Foster Care Program/Contingency Fund Claims
Virginia Department of Social Services,
7 North Eighth Street, Richmond, VA, 23219-1849